Policy & Procedure Manual

EMPLOYEE INJURY/ILLNESS WHILE AT WORK EMPLOYEE RESPONSIBILITIES – HR-XI-22

POLICY:

An employee who is injured or becomes ill while at work will immediately notify their Supervisor/Supervisor on call/Manager/Director.

When an injury has occurred, the employee must give a detailed account of how the injury occurred to the Supervisor/Supervisor on call/Manager/Director so that an Employee Incident Report can be completed.

PURPOSE:

1. To ensure a consistent procedure for employees to follow to alert the Supervisor/Supervisor-on-call/Manager/Director of the injury/illness.

2. To ensure employees receive appropriate care/treatment in case of an injury or illness.

PROCEDURE:

A. Injury While at Work

1. When a workplace injury occurs, obtain immediate first aid as required.

2. If you sustain a critical injury, call 911. (refer to Policy HR-VII-3 for the definition of a critical injury)

3. Immediately report all employee incidents or accidents to the Supervisor/Supervisor on call/Manager/Director, providing details of how the incident occurred, for completion of the incident report (see Appendix A). Assessment of the injury will occur in consultation with the supervisor/supervisor on call. The employee will sign the incident report once completed by the supervisor/supervisor on call/Manager/Director. When the injury is minor, and where possible, the employee will complete the shift.

4. When an injury occurs that does not require emergency care, but the employee feels that he/she is unable to continue working, the employee will make an appointment to see his/her health care professional or will attend a walk in clinic for assessment.

   NOTE: A worker must seek immediate medical attention if he/she/they will be absent (as a result of their injury) from scheduled hours.

5. If immediate emergency treatment is required, the employee will go to the nearest emergency department. Please refer to Policy HR-VIII-4, Transportation for Ill/Injured Employees.

6. Whenever the employee needs to initially seek medical attention in relation to a workplace injury, the employee will take a WSIB Information Package to the health care professional. *The employee is responsible for completing his/her/their name and address on the Treatment Memorandum. The company name, address and firm number will be on the form. The employee will give the form to the treating health care professional. The employee will ensure that the treating health care professional completes the Form 8 and obtain a copy of page 2. If the health care professional does not intend to complete the form immediately, ask them to verbally give you any restrictions/limitations, if applicable.

   * Choose a qualified health care professional knowing that a change cannot be made without the permission of WSIB, except, if the initial visit is to an emergency department/walk-in clinic. The employee may then choose a permanent health care professional. The following Health Care professionals are allowed by WSIB – Medical Doctor/Dentist, Chiropractor, Physiotherapist and Registered Nurse (extended class).

7. Following the visit to the health care professional, the employee will immediately notify the Supervisor/Supervisor- on-call/Manager/Director and the Coordinator Health & Safety by phone re: work status as is indicated on the completed Form 8, page 2 or verbally given, and/or from 8:00 a.m. – 4:00 p.m., Monday to Friday, bring the Employer's copy of the Form to the Coordinator Health & Safety.

8. Under the WSIB legislation, workers have two ways to authorize the release of information regarding Functional Abilities.

The employee may sign:

- A) Section F on Page 2 of Health Professional's Report (Form 8)

  OR

- B) A Worker's Report of Injury/Disease (form 6), which will be sent from WSIB for the worker to sign after the claim has been received and reviewed. You may also complete and submit your form 6 electronically or you can type and print it on the WSIB website once you have a valid claim number. **Employees are required to give the employer a copy of the signed Form 6 at the same time it is submitted to WSIB.**

9. The employee will return to regular duties if there are no restrictions indicated on the form.

10. If the employee is unable to return to regular duties due to restrictions, she/he/they will meet with the Coordinator Health & Safety, and Area Supervisor, and as necessary, a union representative, to develop an ESRTW program. (See Policy HR-X-3). NOTE: Other professionals may be asked to assist.

11. If unable to return to work on modified duties, the employee will contact the Coordinator Health & Safety and Supervisor on a weekly basis, provide information necessary to adjudicate the claim, participate in health care, attend Board-requested and employer – requested health examinations and cooperate in an Early & Safe Return to Work or a Work Reintegration Program.

B. Illness During Work

1. If the employee becomes critically ill at work and is alone, immediately call 911 and then, if able, notify the Supervisor/Supervisor-on-call/Manager/Director who can cover and/or get help, as required.

2. If the employee becomes ill and the illness is not a critical situation, notify the Supervisor/Supervisor-on-call/Manager/Director who will assess the illness and make arrangements to relieve or replace as required.

   a) The Supervisor may request that the employee rest for approximately one half hour if duties permit. If the employee then feels well enough to resume work, s/he may do so.

b) If the employee remains unable to work, she/he/they will either go home or to seek medical attention. The Supervisor/Supervisor on call/Manager/Director will assess the employee's ability to transport themselves home or to seek medical attention. If unable to drive themselves, follow the procedures outlined in HR-VIII-4 – Transportation of an Injured or Ill Employee.

3. The employee will contact the Supervisor in advance if she/he/they is not able to return to work for the next scheduled shift.

4. An absence of 3 or more shifts requires that the employee obtain a Medical Certificate from his/her/their health care professional and submit to the Health and Safety Coordinator/designate. A Medical Certificate may be requested for any absence from employment.

5. The employee may be required to provide medical documentation regarding restrictions, nature of the injury/illness and anticipated length of absence.

6. Designated Human Resources personnel and/or an external agency shall be responsible to adjudicate medical evidence for entitlement to short term sick pay benefits, for qualified employees per the applicable HOODIP plan.

RECOMMENDED BY: Manager, Human Resources **APPENDICES:** 1

OPERATIONAL ACCOUNTABILITY: Administration, Finance, Human Resources, Supportive Living Services (all)

ORIGINAL POLICY DATE: February 1993

AUTHORIZED BY: Executive Director

SIGNATURE: 

POLICY: HR-XI-22
APPENDIX A

Public Services Health & Safety Association

Employee Incident Report

Employee Information

Last Name
First Name
Date of Birth (DD/MM/YY)
Home Telephone No. ( )
Work Telephone No. ( )
Employee ID# / SIN
Address
City/Town Province Postal Code
Division/Dept./Unit
Occupation at time of Injury
Check: ☐Full-time ☐Casual ☐Part-time ☐Student
Years of Experience
Was the employee on the job when the injury occurred? (check) ☐YES ☐NO

Description of Incident

Date of Incident (DD/MM/YY)
Time of day AM/PM
Date Reported (DD/MM/YY)
Time of day AM/PM
To whom was the incident reported?
If report is delayed, please explain why:

State the exact sequence of events leading up to the incident. Include an explanation of what the employee was doing.

Did the accident happen on the employer's premises?

What caused the injury/ illness?

Identify the sizes, weights & types of equipment involved.

Type of Incident (check one – definitions on reverse)
1 ☐Struck/Caught
2 ☐Overexertion
3 ☐Repetition
4 ☐Fire/Explosion
5 ☐Fall
6 ☐Harmful Substances/Environmental
7 ☐Assault
8 ☐Slip/Trip
9 ☐Motor Vehicle Incident

Witnesses

Names, positions, & phone numbers of witnesses or persons having knowledge of the incident.

Cause

Was the accident/illness:
1☐A Sudden, Specific Event/Occurrence? 2☐Gradually Occurring Over Time? 3☐An Occupational Disease? 4☐A Fatality?

Direct causes (check one – see reverse): 1☐Physical/Environmental 2☐Personal
Basic causes (check one – see reverse): 1☐Job factors 2☐Personal factors

Correction

Action(s) Taken	CORRECTED (check box)	PLANNED (check box)	Date (DD/MM/YY)
1	☐	☐	
2	☐	☐	
3	☐	☐	
4	☐	☐	
5	☐	☐	
6	☐	☐	
7	☐	☐	

Examples of Actions:
1. Reinstruction of person involved
2. Reassignment of person
3. Order job safety analysis done
4. Improve personal protective equipment
5. Action to enforce inspection
6. Equipment repair or replacement
7. Correction of conditions done
8. Installation of guard or safety device
9. Actions to improve design/procedure
10. Check with manufacturer
11. Inform all department supervisors
12. Discipline of persons involved
13. Other

Injury

Describe the illness or injury, part of body injured and specify left or right side.

Are you aware of any prior similar or related problem, injury, or condition? If yes, please explain:

No injury (check one)
1☐Hazardous situation

Injury – No WSIB Claim (check one)
1☐First aid
2☐No aid

WSIB Claim Treatment Memorandum (check one)
1☐Health care (medical aid)
2☐Lost time

Occupational Health

Did employee seek medical attention? (check one) 1☐No 2☐Yes
Did employee visit health service? (check one) 1☐No 2☐Yes
Did employee visit emergency? (check one) 1☐No 2☐Yes
If Yes, ER Physician's Name
Tel.No. ( )

Did employee visit family physician? (check one) 1☐No 2☐Yes
If Yes, Physician's Name
Tel.No. ( )
Physician's Address

Will the employee undertake: (check one)
1☐Regular duties
2☐Modified duties
3☐Remain off work

Has the employee had a similar disability? (check one)
1☐Yes
2☐No
3☐Unknown

Check attachments to this report.
1☐Statements
2☐Photographs
3☐Treatment memo
4☐Other – specify:

EMPLOYEE SIGNATURE Date

MANAGER SIGNATURE Date

OCC. HEALTH DEPT. SIGNATURE Date

This information is to be used for completion of WSIB Claim Form 7

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